Wiregrass Eyecare of Ozark

Intake and Consent Form (Please fill this form out in its entirety)

Patient Name: ___________________________ Birth Date: ________________ Age: ________ Gender: _________
Home Phone: _____________________ Cell Phone: _______________________ Email: ____________________________
Mailing Address: ______________________________________ City: _____________ State: _______ ZIP: _________

REASON FOR VISITING OUR OFFICE TODAY: (please check one)
____ Comprehensive Eye Exam ____ Contact Lens Exam ____ Other: ____
Have you had an eye injury/surgery? Y N If so, type of injury/surgery and date:_________________________________
Are you currently pregnant? Y N Any Tobacco Use? Y N
Primary Physician Name: ____ Phone: _____________________
Are you currently taking any medication? Y N If so, list the medication: ______________________________________
____
Are you allergic to any medication? Y N If so, list the medication: ____
____

Ocular/Medical History: (please check all that apply):

	Self	Family		Self	Family		Self	Family
Macular Degeneration			Hypertension			Cancer		
Cataracts			Cholesterol			Stroke		
Glaucoma			Heart Disease			Heart Defects		
Retinal Detachment			Thyroid			Seizures		
Diabetes			Arthritis			Short Gut Syndrome		

For any "Self" checkmarks above, please write year of diagnosis and treatment:_________________________________
____

HIPAA Policy
Wiregrass Eyecare of Ozark will protect and secure all personal and medical health information. No information will be shared without first obtaining consent from the patient.

Dilation Policy
At Wiregrass Eyecare of Ozark patient care is of utmost importance. To perform a full, comprehensive ocular examination dilation drops must be administered to enlarge the pupil of both eyes. This allows the doctor to visualize and analyze the peripheral retina that would otherwise be hidden from view. The side effects of dilation drops last 4-6 hours and include but are not limited to blurry near vision and increased sensitivity to light. Driving and all physical activity should be performed with extra caution when eyes are dilated. Rare adverse effects of dilation drops include but are not limited to headache and vomiting. By signing this and indicating that you decline dilation today, the doctor will be hindered in his/her abilities to perform a full, comprehensive ocular examination and will also keep you (the patient) from filing any charges against the doctor performing the ocular examination, in relation to ocular health and anatomy.

____ Yes, I DO want dilation OR ____ No, I DO NOT want dilation

By signing below, I attest to the truthfulness of the information provided and have read, understood, and agreed to all office terms and policies.

Patient Signature: ____ Date: ______________

Wiregrass Eyecare

OF OZARK

ELECTRONIC COMMUNICATION CONSENT FORM

I, ____ allow do not allow (check one)
Wiregrass Eyecare of Ozark to utilize my email as a primary form of communication until further written notice.

"Allow" will enable Wiregrass Eyecare of Ozark to send me my personal health information including eyeglass and contact lens prescriptions via email. The provided email address below will be used as the official method of communication.

Please list all email addresses authorized to receive information:

____

____

____

"Do Not Allow" will keep physical mailings the primary method of communication.

Signature: ____ Date: _____________________

Wiregrass Eyecare

OF OZARK

How did you hear about us?

___ Post cards

___ Google Search

___ Social Media/Facebook/Instagram

___ Referred by doctor

Doctors Name:__________________________________

___Referred by a friend

Name:____

___ Other

Please specify:___________________________________